REPORT TO OFFICE OF LICENSING
SERIOUS INJURIES OR DEATHS IN A LICENSED PROGRAM

MAIL/FAX THIS REPORT TO YOUR LICENSING SPECIALIST WITHIN 24 HOURS OF SERIOUS INJURY OR DEATH

Provider and Address: _____

Service name and license number where individual **was receiving services** when death/injury occurred:

_____

_____

Consumer Name: _____ Date of Birth _____/_____/_____

Date of death/injury _____/_____/_____ Date of Discovery of death/injury _____/_____/_____

Did the incident involve (check all that apply)?

☐ Seclusion? ☐ Restraint? ☐ Abuse Allegation? ☐ Neglect Allegation? ☐ Assault by Client?
☐ Self-injurious Behavior? ☐ Unexplained? ☐ Other? _____

COMPLETE FOR CRITICAL INCIDENTS ONLY

Did the incident involve?

☐ Loss of consciousness resulting from a serious injury?

☐ Other serious injury:

Type of medical attention required: _____

Status of medical resolution: _____

COMPLETE FOR DEATHS ONLY

Cause (from death certificate) _____

Is autopsy to be performed? ☐ Yes ☐ No If yes, status _____

Was death (check all that apply)?

☐ Expected? ☐ Unexpected? ☐ Suicide? ☐ Referred to Medical Examiner?

State other known facts regarding injury or death (attach additional notes, if necessary):

_____

_____

_____

_____

Was an internal investigation initiated? ☐ Yes ☐ No If yes, indicate date begun: ____/_____/_____

External notifications made (check all that apply and indicate date of notification):

☐ DSS
☐ Local Law Enforcement agency
☐ State Police
☐ Dept. of Health Professions
☐ Dept. of Health
☐ Other (please specify): _____

NAME OF PERSON FILING REPORT: _____

PHONE NUMBER: _____